UNITED STATES OF AMERICA

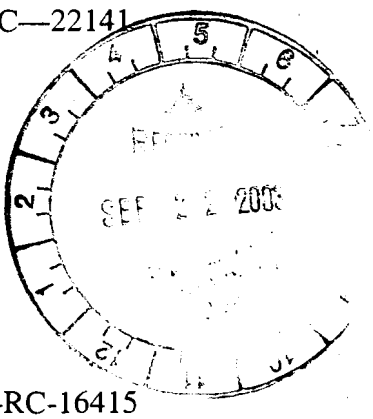
BEFORE THE NATIONAL LABOR RELATIONS BOARD

OAKWOOD HEALTHCARE, INC.
Employer

and

INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE AND AGRICULTURAL IMPLEMENT WORKERS OF AMERICA (UAW), AFL-CIO
Petitioner

Case 7-RC—22141



BEVERLY ENTERPRISES-MINNESOTA, INC., d/b/a GOLDEN CREST HEALTHCARE CENTER
Employer

and

UNITED STEELWORKERS OF AMERICA, AFL-CIO, CLC
Petitioner

Cases 18-RC-16415
18-RC-16416

BRIEF OF PETITIONERS UAW AND USWA and AMICUS CURIAE AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES; AMERICAN FEDERATION OF TEACHERS; COMMUNICATION WORKERS OF AMERICA; INTERNATIONAL BROTHERHOOD OF TEAMSTERS; INTERNATIONAL UNION OF OPERATING ENGINEERS; LABORERS' INTERNATIONAL UNION OF NORTH AMERICA; OFFICE AND PROFESSIONAL EMPLOYEES INTERNATIONAL UNION; SERVICE EMPLOYEES INTERNATIONAL UNION; and UNITED FOOD AND COMMERCIAL WORKERS

Daniel W. Sherrick, General Counsel
Blair Simmons, Esq.
UAW, International Union
8000 East Jefferson Avenue
Detroit, MI 48214-2699
(313) 926-5216

Paul Whitehead, General Counsel
Daniel M. Kovalik, Esq.
United Steelworkers of America
Five Gateway Center, Suite 807
Pittsburgh, PA 15222
(412) 562-2549

John C. Dempsey, General Counsel
Larry P. Weinberg, General Counsel
AFSCME, Office of General Counsel
1101 17th Street, N.W., Suite 900
Washington, D.C. 20036
(202) 775-5900

Patrick M.. Scanlon, General Counsel
Communications Workers of America
502 Third Street, N.W., Suite 800
Washington, D.C. 20001
(202 434-1234

Richard Griffin, General Counsel
International Union of Operating
Engineers
1125 17th Street, N.W.
Washington, D.C. 20036
(202) 429-9100

Melvin S. Schwarzwald, General Counsel
Office and Professional Employees
International Union
Schwarzwald & McNair
1300 East Ninth Street, Suite 616
Cleveland, OH 44114
(216) 566-1600

Robert E. Funk, Jr., General Counsel
United Food and Commercial Workers
1775 K Street, N.W.
Washington, D.C. 20005
(202) 223-3111

David J. Strom, General Counsel
American Federation of Teachers
555 New Jersey Avenue, N.W.
Suite 200
Washington, D.C. 20001
(202) 393-7472

Patrick J. Szymanski, General Counsel
International Brotherhood of Teamsters
25 Louisiana Avenue, N.W.
Washington, D.C. 20001
(202 624-6945

Michael S. Bearse, General Counsel
Laborers' International Union of
North America
906 16th Street, N.W.
Washington, D.C. 20006
(202) 737-8320

Judith A. Scott, General Counsel
Service Employees International Union
1313 L Street, N.W.
Washington, D.C. 20005
(202) 898-3453

TABLE OF CONTENTS

PAGE

TABLE OF AUTHORITIES

CASES ***PAGE***

LEGISLATIVE MATERIALS

OTHER

Kaiser Family Foundation/Harvard School of Public Health, *Survey of Physicians and Nurses*, July 1999 ..... 4, 9

National Institute for Occupational Health and Safety, *Violence: Occupational Hazards in Hospitals* (April, 2002) 7, 8

Needle-stick & sharps safety survey, 33 Nursing2003 9 (September 2003) 6

Nelson, Audrey, et al., *Myths and Facts about Back Injuries in Nursing* (comment), 103 American Journal of Nursing 2, 32 (2003) 6, 7

President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry (1998) 12

Rambur, Betty, et al, *A Statewide Analysis of RNs Intention to Leave Their Profession*, 51 Nursing Outlook 182 (2003) 8

Smith, Leef, *For a Nursing Shortage, An Older Cure*, Washington Post, May 2, 2003 2

Stricklan, P., et al., *Characteristics of Nursing Staff in Long-Term Care Facilities: Their Training, Experience and Perceived Proficiency Levels, 36 Nursing Homes 22 (1987)* 8, 11

White, Ronald D., *Hospitals Seek Cures for Nursing Shortage*, LA Times, April 21, 2002 2

The petitioners International Union, United Automobile, Aerospace and Agricultural Implement Workers of America and United Steelworkers of America and amici American Federation of State, County and Municipal Employees; American Federation of Teachers; Communication Workers of America; International Brotherhood of Teamsters; International Union of Operating Engineers; Laborer International Union of North America; Office and Professional Employees International Union; Service Employees International Union; and United Food and Commercial Workers submit this brief to address the issues raised by the two cases before the Board involving the protected status of nurses: *Beverly Enterprises-Minnesota, Inc.*, Case 18-RC-16415 and 16416, and *Oakwood Healthcare, Inc.*, Case 7-RC-22141.

INTEREST OF THE AMICUS CURIAE

The two petitioners and all of the amici labor organizations affiliated with the AFL-CIO represent nurses.[1] Together, AFL-CIO unions represent approximately 400,000 registered nurses (RNs) and licensed practical nurses (LPNs)[2] employed in acute care hospitals, nursing homes and other settings.

ARGUMENT

I. Congress Intended to Protect Nurses

The brief of Amicus AFL-CIO explains in detail what is actually a very simple but absolutely fundamental point – that Congress has expressed its specific intent that the Act protect nurses. We do not reiterate this persuasive explanation here, but merely emphasize two of its foundations.

First, when Congress extended the coverage of the Act to nonprofit hospitals in 1974, it obviously and expressly intended the Act's protections to extend to nurses who comprise 25% of the hospital workforce.[3]

---

[1]The United American Nurses is also affiliated with the AFL-CIO and has filed a separate amicus brief in these cases together with the American Nurses Association.

[2]LPNs are called Licensed Vocational Nurses in California.

[3]U.S. Bureau of Labor Statistics (BLS), U.S. Department of Labor, *Occupational Outlook*

(continued...)

Second, at that same time, Congress (1) recognized that nurses routinely "give[] direction to other [less highly trained] employees . . . which direction is incidental [to] the [nurses'] treatment of patients," (2) acknowledged that the Board had held that such direction did not make nurses supervisors excluded from the protection of the Act, and (3) instructed the Board to continue to decide cases "in this manner." Sen. Rep. No. 93-766, 93d Cong., 2d Sess. 6 (1974); H.R. Rep. No. 93-1051, 93d Cong., 2d Sess. 7 (1974).

Congress clearly intended that nurses, engaged in their traditional and virtually universal functions, including delegating discrete tasks to less skilled employees, be protected by the Act. The Board must continue to honor this intent.

II. Protecting Nurses Will Further the Purposes of the Act

In *Beth Israel Hospital v. NLRB*, 437 U.S. 483, 497 (1978), the Supreme Court recognized that "[t]he elimination of the nonprofit-hospital exemption [in 1974] reflected Congress' judgment that hospital care would be improved by extending the protection of the Act to nonprofit health-care employees." Specifically, "Congress found that wages were low and working conditions poor in the health-care industry, and that as a result, employee morale was low and employment turnover high." *Id.* "Congress determined that the extension of organizational and collective-bargaining rights would ameliorate these conditions and elevate the standard of patient care." *Id.* at 497-98.

Today, almost 30 years after the healthcare amendments were adopted, it is universally recognized that there is a crises in nursing care with roots in the very adverse working conditions Congress sought to ameliorate by extending the protection of the Act to healthcare workers.[4] The

---

(...continued)
Handbook 269 (2002-03), *available at* http://www.bls.gov/oco/pdf/ocos083.pdf.

[4]*See, e.g.,* Leef Smith, *For a Nursing Shortage, An Older Cure*, Washington Post, May 2, 2003, at B1; Sara Corbett, *The Last Shift*, N.Y. Times, March 16, 2003, at section 6, p.58; Ronald D. White, *Hospitals Seek Cures for Nursing Shortage*, LA Times, April 21, 2002, at part 3, p. 1.

popular press reports that the nursing profession is in a "death spiral."[5]

> [W]e are careening toward outright disaster: by 2020, more nurses will be departing the profession than entering it, leaving the health care system -- which will then be stuffed with octogenarian baby boomers -- with a projected shortfall of 800,000 nurses. Seeing little in the way of positive change, experts are no longer talking about a "nursing shortage" but rather a "nursing crisis."[6]

Research has demonstrated that adverse working conditions are contributing to this "nursing crisis" and thus are having a direct and immediate impact on the quality of patient care.

A. Low Wages and Benefits

Senator Cranston, the floor manager of the healthcare amendments in the Senate, explained in 1974 that "hospital workers are still notoriously underpaid." Quoted in *Beth Israel*, 437 U.S. at 498 n. 14. This remains true today of nurses in both hospitals and nursing homes.

Hospital nurses are the largest segment (3 out of 5) of the 2.2 million nurses in the United States.[7] The median annual earnings for RNs in hospitals was $45,780, with 10% of all RNs earning under $31,890 in 2000.[8] RNs in nursing and personal care facilities earned a median income of $41,330.[9] Overall, LPNs earned a median salary of $29,440 in 2000, with the lowest 10% earning less than $21,520.[10] One survey found that the wages and benefits of nursing personnel in nursing homes to be "scandalously low."[11] In the *Beverly* case before the Board, the

---

[5]Corbett, *The Last Shift*, at 1.

[6]*Id.*

[7] BLS, *Occupational Outlook Handbook* 269 (2002-03), available at http://www.bls.gov/oco/pdf/ocos083.pdf.

[8] The mean annual income for all nurses in 2001 was $48,240. BLS, *National Occupational Employment and Wage Estimates* (2001), available at http://www.bls.gov/oes/2001/oes291111.htm.

[9] *Id.*

[10] BLS, *Occupational Outlook Handbook* 269 (2002-03), available at http://www.bls.gov/oco/pdf/ocos083.pdf.

[11]Charlene Harrington, *Wages & Benefits of Nursing Personnel in Nursing Homes*, 8 Nursing
(continued...)

LPNs earn as little as $9.12 per hour – less than $19,000 per year (assuming they work full-time). *Beverly*, D&D at 5.

In 1999, 26% of nurses felt that they were not making enough money.[12] While nurses are often required to work overtime, many also do it because it is necessary to supplement their income. One in ten RNs had more than one job in 2000.[13]

Most nursing homes do not provide health benefits to their staff.[14] Retirement issues are also increasingly important as fewer young people are entering the field and the average age of nurses has climbed. In 2000, the average of nurses was 43.3, and the General Accounting Office estimates that by the year 2010, 40% of all RNs will be over 50.[15]

B. Physical and Emotional Demands

Nursing is a physically and emotionally demanding job, made more difficult by forced overtime and under staffing. Nurses work every day of the week at all hours of the day and night. They provide direct, hands-on care to the ill, the disabled, the elderly and the dying. According to the Bureau of Labor Statistics:

> Nurses may spend considerable time walking and standing. They need emotional stability to cope with human suffering, emergencies, and other stresses. Patients in hospitals and nursing homes require 24-hour care; consequently, nurses in these institutions may work nights, weekends, and

---

(...continued)
Econ. 378, 378 (1990).

[12] Kaiser Family Foundation/Harvard School of Public Health, *Survey of Physicians and Nurses*, July 1999, *available at* http://www.kff.org/content/1999/1503/PhysiciansNursesSurveyChartPack.pdf.

[13] BLS, *Occupational Outlook Handbook* 269 (2002-03), *available at* http://www.bls.gov/oco/pdf/ocos083.pdf.

[14] Institute of Medicine, *Nursing Staff in Hospitals and Nursing Homes: Is it Adequate?* (hereinafter *IOM Study*) 160 (1996); Charlene Harrington, *Nursing Facility Quality, Staffing and Economic Issues*, in *id.* at 453, 466.

[15] American Association of Colleges of Nursing (AACN), *Nursing Shortage Fact Sheet* (April 2003), *available at* http://www.aacn.nche.edu/Media/Backgrounders/shortagefacts.htm.

holidays. RNs also may be on-call (available to work on short notice).[16]

In nursing homes, LPNs "provide routine bedside care."[17] The government reports that most LPNs work a 40-hour week, but are required to work nights, weekends, and holidays. LPNs also "stand for long periods and help patients move in bed, stand, or walk," and they deal with heavy workloads, hazardous conditions, and confused, irrational, agitated, and uncooperative patients.[18]

Because of the nursing shortage, high turnover, and under staffing, nurses are often forced to work overtime. The problem has become so sever that six states have passed laws limiting the practice.[19]

Using any measure, nursing is hard work.

C. Injuries

Nurses face many dangers at work associated with lifting and moving patients, treating patients with infectious diseases (e.g., tuberculosis and AIDS), using needles and other sharp instruments, using equipment capable of producing electrical shocks, and working around compressed gasses, radiation, chemicals, and biological agents.[20] In 2001, over 458,000 non-fatal occupational injuries were reported in hospitals and nursing care facilities.[21] The rate of occupational injuries and illnesses for hospital employees was 8.8 per 100 workers and in nursing

---

[16] BLS, *Occupational Outlook Handbook* 269 (2002-03), *available at* http://www.bls.gov/oco/pdf/ocos083.pdf.

[17] Id.

[18] *Id.*

[19] The states are: Maine, 26 M.R.S.§603 (2003); Maryland, Md. Labor & Employment Code Ann. § 3-421(2003); Minnesota, Minn.Stat § 181.275 (2002); New Jersey, N.J. Stat § 34:11-56a31 et seq. (2003); Oregon, ORS § 441.166 (2001); and Washington, RCW § 49.28.130 to 49.28.150 (2003).

[20] BLS, *Occupational Outlook Handbook* 269 (2002-03), *available at* http://www.bls.gov/oco/pdf/ocos083.pdf.

[21] BLS, *Workplace Injuries and Illnesses in 2001*, (December 19, 2002), Table 1, *available at* http://www.bls.gov/news.release/osh.t01.htm.

homes, this rate was 13.5.[22] The average across all private industries in 2001 was only 5.7.[23] Nursing home occupational injury and illness rates exceeded those in coal mining, construction, manufacturing, transportation, auto repair and, even, professional sports.[24]

38% of nurses have had back injuries: "Repeated lifting and forceful movements associated with patient care activities lead to serious health problems for health care workers. Lifting, transferring, and repositioning patients are the most common tasks that lead to injury."[25] In 2000, the number of work days missed because of back injuries was 181.6 per 10,000 full time nursing home workers.[26] In hospitals, this rate was 90.1, compared to 70 for construction workers and 56.3 for miners.[27]

600,000 - 1,000,000 RNs and other health care workers are stuck by needles, infecting 1,000 employees with diseases such as HIV and Hepatitis every year.[28] According to the Center for Disease Control, of the 384,325 reported health worker needlestick injuries in 2001, 44% were to nurses.[29]

In 1999, hospital workers were assaulted at a rate of 8.3 per 10,000 workers, leading to a

---

[22] *Id.*

[23] *Id.*

[24]BLS, *Occupational Injuries and Illnesses: Industry Date (1989-current), at* http://data.Bls.gov/cgi-bin/dsrv?sh.

[25]American Nursing Association (ANA), *Preventing Back Injuries: Safe Patient Handling and Movement*, (2002), *available at* http://www.nursingworld.org/osh/ergonomics.pdf.

[26] Audrey Nelson, et al., *Myths and Facts about Back Injuries in Nursing* (comment), 103 American Journal of Nursing 2, 32 (2003).

[27] *Id.*

[28] American Nursing Association (ANA), *Needlesticks: A Preventable Epidemic, at* http://www.nursingworld.org/needlestick/safeneed.htm (last checked Sept. 22, 2003).

[29] *Needle-stick & sharps safety survey*, 33 Nursing2003 9, 32 (September 2003) (citing Center for Disease Control statistics).

total of 2,637 non-fatal assaults.[30] This rate far exceeds other industries, but is unsurprising given the stressful workplaces and the exposure to patients with psychological disorders.

This extraordinary threat is also increasing, for while the rate of occupational injury and illness in private industry as a whole has remained constant or declined slightly since 1980, the rate for nursing homes has increased by over sixty percent.[31]

The hazards prevalent in hospitals and nursing homes generally require nurses to "observe rigid guidelines to guard against disease and other dangers."[32] Furthermore, nurses are often discouraged from reporting injuries:

> There are numerous barriers to reporting a work-related injury or illness. Many [nurses] fear repercussions such as disciplinary action, stigmatization as a complainer, harassment by supervisors and coworkers, denial of opportunities for promotion, and termination of employment.[33]

D. Poor Working Conditions Lead to Turnover and Under Staffing

In 1974, Senator Cranston summarized the evidence that had been presented to Congress that "[t]he long hours worked and the small monetary reward received by hospital workers result in a constant turnover with a consequent threat to the maintenance of an adequate standard of medical care." Quoted in *Beth Israel*, 437 U.S. at 498 n. 14. "[B]oth management and union witnesses," Senator Cranston stated, "reported lower turnover after unionization than before." *Id.* Today, it is beyond dispute that poor working conditions are contributing significantly to the current nursing shortage.

Numerous studies and surveys report that working conditions and resulting job dissatisfaction are factors in the current nursing shortage. The American Association of Colleges

---

[30] U.S. Department of Health and Human Services, National Institute for Occupational Health and Safety, *Violence: Occupational Hazards in Hospitals* (April, 2002), *available at* http://www.cdc.gov/niosh/2002-101.htm.

[31] *IOM Study* at 170.

[32] BLS, *Occupational Outlook Handbook* 269 (2002-03), *available at* http://www.bls.gov/oco/pdf/ocos083.pdf.

[33] Nelson, *Myths and Facts*, at 32.

of Nursing found that "[j]ob burnout and dissatisfaction are *driving* nurses to leave the profession."[34] Hospital nurses report dissatisfaction with their jobs at a rate four times greater than the average reported by employees in other industries.[35] Over 40% of hospital nurses are dissatisfied with their jobs.[36] One in three hospital nurses under 30 years old is planning to leave his or her current job within a year.[37] One-fifth of nurses surveyed in a Vermont study said that they intended to leave their current positions.[38] In 2002, the Journal of the American Medical Association reported that 43% of nurses who experience high burnout and dissatisfaction intend to leave their current job within twelve months. The average RN turnover rate in acute care hospitals is 21.3%[39] and turnover rates at nursing homes is 48.9%.[40] One study found that the average tenure for both RNs and LPNs in nursing homes was only 1.5 years.[41]

---

[34]American Association of Colleges of Nursing (AACN), *Nursing Shortage Fact Sheet* (April 2003), *available at* http://www.aacn.nche.edu/Media/Backgrounders/shortagefacts.htm.

[35] Linda Aiken, et al, *Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction*, 288 JAMA 1987, 1987 (2002).

[36]American Association of Colleges of Nursing (AACN), *Nursing Shortage Fact Sheet* (April 2003), *available at* http://www.aacn.nche.edu/Media/Backgrounders/shortagefacts.htm. (citing www.healthaffairs.org); American Health Care Association, *Results of the 2002 AHCA Survey of Nursing Staff Vacancy and Turnover in Nursing Homes* (February, 2003) *available at* http://www.ahca.org/research/rpt_vts2002_final.pdf.

[37]American Association of Colleges of Nursing (AACN), *Nursing Shortage Fact Sheet* (April 2003), *available at* http://www.aacn.nche.edu/Media/Backgrounders/shortagefacts.htm.

[38]Betty Rambur, et al, *A Statewide Analysis of RNs Intention to Leave Their Profession*, 51 Nursing Outlook 182, 182 (2003).

[39]American Organization of Nurse Executives, *Acute Care Hospital Survey of RN Vacancy and Turnover Rates* 7 (January 2002), *available at* http://www.wha.org/workForce/pdf/aone-surveyrnvacancy.pdf.

[40]American Association of Colleges of Nursing (AACN), "Nursing Shortage Fact Sheet", *available at* http://www.aacn.nche.edu/Media/Backgrounders/shortagefacts.htm (citing http://www.healthaffairs.org); American Health Care Association, *Results of the 2002 AHCA Survey of Nursing Staff Vacancy and Turnover in Nursing Homes* (February, 2003), *available at* http://www.ahca.org/research/rpt_vts2002_final.pdf.

[41]P. Stricklan, V. Enhorn, C. Jones, *Characteristics of Nursing Staff in Long-Term Care Facilities: Their Training, Experience and Perceived Proficiency Levels*, 36 Nursing Homes 22,

(continued...)

In 1999, 69% of nurses felt that their workplaces were understaffed.[42] Their employers agreed as even as early as 1990, 60% of nursing homes reported one or more vacancies among both RNs and LPNs.[43] Under staffing takes a toll on nurses. Between April 1998 and November 1999, high emotional exhaustion was reported by 43.2% of nurses.[44] Exhaustion and dissatisfaction rates among "nurses were strongly and significantly associated with patient-to-nurse ratios."[45] The Journal of the American Medical Association reports that an increase of 1 patient per nurse to a hospital's staffing level increased burnout by 23% and job dissatisfaction by 15%.[46]

Much of this data is summarized in the following table:

	RNs	LPNs
Population (2000)[47]	2.2 million	700,000
Median Wages (2001)[48]	$45,780 (hospitals) $41,330 (nursing homes)	$29,440 (all) $29,980 (nursing homes)

---

[41](...continued)
25 (1987).

[42]Kaiser Family Foundation/Harvard School of Public Health, *Survey of Physicians and Nurses*, July 1999, *available at* http://www.kff.org/content/1999/1503/PhysiciansNursesSurveyChartPack.pdf.

[43]Harrington, *Wages & Benefits of Nursing Personnel*, at 379.

[44]Aiken, *Hospital Nurse Staffing*, at 1990.

[45]*Id.*

[46]*Id.*

[47]BLS, *Occupational Outlook Handbook* 269, 288 (2002-03), *available at* http://www.bls.gov/oco/pdf/ocos083.pdf.

[48]*Id.*

Vacancy Rates at Nursing Homes (2002)[49]	15.0%	13.2%
Turnover Rates at Nursing Homes (2002)[50]	48.9%	48.9%
Vacancy Rates at Hospitals (2001)[51]	18.5% (staff RNs)	14.6%
Turnover Rates at Hospitals (2001)[52]	56.2% (staff RNs)	53.6%

E. Under Staffing and Turnover Lead to Substandard Care

Under staffing and turnover, in turn, harm patients and residents. In 2002, the Joint Committee on Accreditation of Healthcare Organizations reported, "The combination of too few nurses and nursing support personnel, coupled with excessive paperwork and administrative tasks, leaves too little time for nurses to spend on direct patient care."[53]

Under staffing among nurses is linked to adverse outcomes among patients. The prestigious Journal of the American Medical Association reports that the odds of patient death increased by 7% for every additional patient in the average nurse's case load in the hospital, and the percentage increase in risk grows with each patients added.[54] The committee of experts

---

[49]American Health Care Association (AHCA), *Results of the 2002 AHCA Survey of Nursing Staff Vacancy and Turnover in Nursing Homes* 4 (February, 2003), *available at* http://www.ahca.org/research/rpt_vts2002_final.pdf.

[50]*Id.*

[51]AHCA, *The 2001 AHCA Nursing Position Vacancy and Turnover Survey* 8 (February 7, 2002), *available at* http://www.ahca.org/research/vacancysurvey_020207.pdf.

[52]*Id.*

[53]Joint Commission on Accreditation of Healthcare Organizations, *Healthcare at the Crossroads* 11 (2002) *available at* http://www.jcaho.org/about+us/public+policy+initiatives/health+care+at+the+crossroads.pdf.

[54]Aiken, *Hospital Nurse Staffing*, at 1990.

appointed by the Institute of Medicine to investigate this issue similarly concluded that "[t]he preponderance of evidence from a number of studies using different types of quality measures has shown a positive relationship between nursing staff levels and quality of nursing home care, indicating a strong need to increase the overall level of nursing staff in nursing homes."[55]

"High turnover rates and short employment periods for nursing staff, particularly in nursing homes are considered detrimental to patients and patient care."[56] Turnover is "a major problem in continuity of care, which is an important factor in providing good care to residents with chronic conditions. Disruption of staff leads to residents having to constantly 'train' staff, problems in carrying through care plans, inaccurate assessments because of failure to be familiar with the baseline status of a resident, and failure of a facility to fully develop a philosophy of caring."[57]

Government agencies, nurses' organizations, and industry groups widely agree that comprehensive changes to nurses' work environments must take place to improve conditions for nurses, resolve the current shortage, reduce medical errors, and improve patient care overall. The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry concluded:

> Efforts must be made to address the serious morale problems that exist among health care workers in many sectors of the industry. Health care organizations should acknowledge morale problems by taking steps to address the concerns of . . . nurses, and other health care workers regarding professional autonomy, rising workloads, nonproductive paperwork, and employment security. Organizations undergoing restructuring should involve their employees in the planning and implementation of such changes.[58]

---

[55]*IOM Study* at 153.

[56]Stricklan, *Characteristics of Nursing Staff*, at 25.

[57]J. Johnson, M. Cowles, S. Simmens, *Quality of Care and Nursing Staff in Nursing Homes*, in *IOM Study* at 153.

[58]President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry (1998), *available at* http://www.hcqualitycommission.gov/final/chap13.html (emphasis in original).

Congress has clearly expressed its intention to allow nurses to be involved in these critical efforts to address the current crises in nursing care through the processes of collective bargaining. It is more important now than ever before that the Board continue to honor Congress' intent.

III. What Nurses Do

What most nurses do primarily is provide direct, hands-on care to sick, disabled or elderly patients. Such nursing care is not limited to handing out medicines and taking temperatures, but covers the entire spectrum of care from creating individualized nursing care plans, assessing health status and updating patient records, to wound care, medical treatments and monitoring intravenous procedures, to meeting patients' and residents' basic physical needs such as bathing, feeding, and emptying bedpans, and to providing emotional support. *But* what is critical for the Board to understand is that the ordinary, direct provision of these nursing services in both hospitals and nursing homes, by both RNs and LPNs, while they are serving as charge nurses and staff nurses, involves the delegation of discrete tasks both to other nurses and to less skilled personnel and the coordination and oversight of all care being provided to the nurses' patient. In other words, the Board must understand that *if* the performance of the functions at issue in these cases renders the nurses supervisors, *all* nurses are supervisors.

RNs must graduate from an approved nursing program (which range from two to four years depending on the degree sought), pass a national licensing exam and are subject to state practice laws.[59] As set out in the BLS *Occupations Classification Manual,* a RN:

> Provides comprehensive general nursing care to patient whose conditions and treatment are normally uncomplicated. Follows established procedures, standing order, and doctor's instructions. Uses judgment in selecting guideline appropriate to changing patient conditions. Routine duties are performed independently, variations from established routines are performed under specific instructions. Typical assignments include:
> Staff. Prepares hospital or nursing home patients for tests, examination, or treatment; assists in responding to emergencies;

---

[59]BLS, *Occupational Outlook Handbook* 269 (2002-03), *available at* http://www.bls.gov/oco/pdf/ocos083.pdf.

> records vital signs and effects of medication and treatment of patient charts; and administers prescribed medications and intravenous feedings.[60]

A more experienced nurse, in addition to the above, "usually performs more complex procedures such as: administering blood transfusions; managing nasal-pharyngeal, gastric suction, and other drainage tubes; using special equipment such as ventilator devises, resuscitators, and hypothermic units, or closely monitoring postoperative and seriously ill patients."[61]

By contrast, LPN training generally consists of a one-year program administered through a technical or vocational school.[62] A high school diploma is not a universal requirement for entry into such programs.[63] LPNs are trained in basic nursing concepts and patient care related subjects in order to perform basic bedside care.[64] LPNs provide "a level of service between the NA [nursing assistant] and the RN." Specifically, LPNs do the following:

> LPNS are licensed to provide practical or vocational nursing care to patients. . . . As part of a nursing team, [LPNs] assists patients in attending to their personal hygiene; measures and labels routine specimens, records vital signs; provides routine treatments such as compresses, enemas, sterile dressings, and sitz bath; prepares and administers commonly prescribed medications; observes and reports on patient conditions; and teaches patient self care, repeating instructions previously provided by professional staff.[65]

In both hospitals and nursing homes, nurses are assisted in the performance of their professional duties by a variety of less skilled or more specialized personnel. Such staff includes Certified Nurses Aids or Assistants (CNAs), orderlies, attendants, various types of technicians,

---

[60] BLS, *Occupational Outlook Handbook* 269 (2002-03), *available at* http://www.bls.gov/oco/pdf/ocos083.pdf.

[61] *Id.*

[62] *IOM Study* at 76-77.

[63] BLS, *Occupational Outlook Handbook,* 227.

[64] *Id.*

[65] *Id.*

clerks and secretaries, and others.[66] Nurses must and do call on these other workers for assistance and provide general oversight of their work as it relates to the nurses' patients. However, the principal function of both staff and charge nurses is to provide direct patient care and any direction they give to others is ancillary to this. The consistent finding in the case law is that such direction consumes a very low percentage of the nurses' work day. *See, e.g., Rest Haven Living Ctr., Inc.*, 322 NLRB 210, 210 (1996) ("90 percent of [the nurses'] job consisted of caring for the residents of the nursing home"). If such direction is held to be sufficient to constitute assignment or direction within the meaning of the Act's definition of supervisor, virtually all nurses will be classified as supervisors and deprived of statutory protection.

One Regional Director has already mistakenly excluded all 140 registered nurses in an acute care hospital as supervisors. *See Pavia Hospital*, No. 26-RC-8289 (Oct. 6, 2000). In the *Beverly* case, the Employer seeks to exclude 19 of 20 nurses and in the *Oakwood* case the Employer seeks to exclude almost all of the 220 Rns. *Oakwood*, D&D at 12. A construction of the Act that would exclude virtually all nurses is inconsistent with congressional intent, is not required by the terms of the Act, is not required by the Supreme Court's decision in *NLRB v. Kentucky River Community Care, Inc.*, 532 U.S. 706 (2001), and would be bad labor relations and public policy.

IV. The Employers Failed to Carry Their Burden of Proving that the Nurses at Issue Are Supervisors

The AFL-CIO is its amicus brief sets forth complete answers to the questions of statutory construction posed by the Board. We concur with the AFL-CIO and do not reiterate its arguments here. Rather, below, we apply the appropriate legal standards to the facts of these two

---

[66]According to the Institute of Medicine, "Ancillary nursing personnel, nursing support personnel, assistive personnel, nurse extenders, unlicensed nursing personnel, multi-competent workers, nurse assistants or aides are all generic terms used to refer to the various clinical and nonclinical jobs that augment nursing care. This group of employees includes an array of support nursing personnel including certified nurse assistants, orderlies, operating room technicians, home health aides and others." *IOM Study* at 60 n. 1.

cases.

A. Oakwood Failed to Prove the Nurses are Supervisors

The Employer seeks to exclude RNs employed at Oakwood on the grounds that they have supervisory authority while acting as Charge Nurses.[67] The Employer contends that the Charge Nurses both assign and responsibly direct employees.[68]

1. Rotating and Occasional Assumption of Charge Nurse Role is Not Sufficient to Deprive Nurses of the Act's Protection

Before considering whether the Employer has carried its burden of proving that Charge Nurses perform supervisory functions, the Board should consider whether the occasional assumption of the Charge Nurse role is sufficient to render those nurses who are not Permanent Charge Nurses exempt supervisors even assuming that they perform supervisory functions when acting as Charge Nurses..

a. Rotation of Coordinating Function Among Peers Does Not Render Them Supervisors

As explained in the brief of Amicus AFL-CIO, when employees simply rotate into a leadership or coordinating role so that on one day they are assigning and directing employees who the next day may be assigning and directing them, all the employees who rotate into the role are not rendered supervisors. With the exception of the few Permanent Charge Nurses, this is all that occurs at this Hospital. As the RD found, "A charge nurse assigning a patient to a staff nurse one day, can the next day be assigned a patient from the same staff nurse, when the roles are reversed." D&D at 20.

---

[67]The Regional Director stated, "The Employer submits that the primary indicia that the RNs are supervisors is their responsibility when serving as charge nurses to assign and direct other nurses, and adjust grievances." D&D at 3. In its Brief on Review, the Employer states that the only issue on review is the "determination that the Employer's charge nurses are not supervisors." Employer Brief on Review at 1. Thus, there is no contention before the Board that the nurses are supervisors *except* when they are acting as charge nurses.

[68]The Employer also contends on review that the Charge Nurses adjust grievances. Because the evidence showing that Charge Nurses, at most, play an informal role in resolving minor disputes is clearly insufficient to prove that they adjust grievances as that term has been consistently construed in Board cases, this argument is not addressed here.

That the Rotating Charge Nurses are not aligned with management and continue to share a community of interest with their fellow nurses is made clear by the fact that in many units the nurses themselves decide who should serve in the role of Charge Nurse. Tr. at 345, 372, 463, 476. Management does not even know how the nurses make this decision. Tr. at 412. One Assistant Clinical Manager testified, "I don't have any concrete idea of how they do it but because they are educated, professional people, they can decide amongst them." Tr. at 478. The Assistant Clinical Manager for the Med Surg East and West Units testified, "the nurse know just by who is charge today, who was charge last week, whose turn is it to be charge next week . . . . But being the professional, educated people they are, by the nature of the job . . . they certainly can make a decision amongst themselves as to who will be charge." Tr. at 476. The Board cannot hold that these nurses are "employed as a supervisor" as required by § 2(3) of the Act when it is their fellow employees who select them for this role. They are not "vested with . . . genuine management prerogatives," *Legislative History of the Labor-Management Relations Act*, 1947 at 410 (GPO 1974) (Senate Report on amendments), when it is their peers who do the vesting.

A Charge Nurse is simply a team leader. That was the term used by the Assistant Clinical Manager in the Mental Health Unit to describe the Charge Nurses, "They're kind of like a team leader." Tr. at 308. In fact, elsewhere in the same hospital system, the term "Team Leader" is used to describe the same role. Tr. at 107-08.

b. Rotating Charge Nurses Do Not Have Alleged Supervisory Duties During a Majority of Their Working Hours

Nurses who are not Permanent Charge Nurses may assume the role in two ways. First, in the units with a Permanent Charge Nurse, other nurses assume the function during those days (usually two) each week when the Permanent Charge Nurses is not working. Second, in the units

without a Permanent Charge Nurse, most[69] of the nurses in the unit rotate through the role. The evidence does not reveal a consistent pattern in the assumption of the Charge Nurse role by nurses not serving as Permanent Charge Nurses. Obviously, in units with a Permanent Charge Nurse, other nurses could assume the role no more than twice per week, except when the Permanent Charge Nurse was on vacation or otherwise absent. Tr. at 343, 370. Even in units where there is no Permanent Charge Nurse, several nurses testified they assumed the role only once or twice every two weeks. D&D at 12; tr. at 561.

Amicus AFL-CIO has persuasively argued that employees should not be excluded from the protections of the Act as a supervisor unless they possess supervisory authority during a majority of their working hours. In this case, this is not true of any of the rotating charge nurses.

Even if the Board instead applies a "regular and substantial" standard, the Rotating Charge Nurses do not satisfy either prong of the test. First, no "regular" pattern of rotation was established. In fact, at least one manager testified that there was "no particular order" to the selection of Rotating Charge Nurses. Tr. at 438. As set forth above, in some units management does not even know how the nurses rotate into the role. Second, an average of two days serving as Charge Nurse during a two week period is not "substantial."

Furthermore, in considering whether the occasional assumption of the alleged supervisory functions should exempt the nurses from the protections of the Act, the Board should consider two facts. First, the overwhelming majority of the nurses serve as either Permanent or Rotating Charge Nurses. D&D at 12. On some units, every RN is either a rotating or permanent Charge Nurse. Tr. at 164-65. Thus, if simply rotating into this role is sufficient to render the nurses supervisors, almost all the nurses in the Hospital will be excluded from the protection of the Act.

Second, even during the few days in a two week period when non-Permanent Charge Nurses possess the authority of Rotating Charge Nurses, it cannot be disputes (as explained

---

[69]The evidence shows that a few nurses never assumed the role either because they chose not to or because they were not sufficiently experienced.

below) that the vast majority of their working hours are spent on hands-on patient care and other nonsupervisory functions. In fact, the function of assigning patients to nurses (the function primarily relied on by the Employer as evidence of supervisory status) takes only a few minutes per day to perform. Thus, putting points one and two together, the Employer is asking the Board to strip virtually every nurse in the Hospital of the protections of the Act based on the performance of alleged supervisory functions during a few minutes of only approximately two shifts every two weeks. Such a result is surely inconsistent with the Supreme Court's instruction to "take care to assure that exemptions from [the Act's] coverage are not so expansively interpreted as to deny protection to workers the Act was designed to reach." *Holly Farms Corp. v. NLRB*, 517 U.S. 392, 399 (1996).

2. The Employer Failed to Prove Assignment or Direction

Before considering the evidence of assignment and direction, it must be clearly understood that the vast majority of what Charge Nurses do is not even arguably supervisory. First, the Charge Nurse, along with other staff on the unit, listens to report from the outgoing nurses at the start of the new shift. Tr. at 260, 332, 565. Second, in most units, on most shifts, the Charge Nurse takes a full or, at least, partial load of patients. Tr. at 102-04, 296-97, 328, 393, 395, 568. In fact, in some units, all Charge Nurses "take a full load of patients." Tr. at 447. In the Emergency Room, while the Charge Nurse does not assume a patient load, she serves as the triage nurse, seeing all patients as they arrive at the hospital and assessing the immediacy of their need for care. Third, Charge Nurses act as the point of contact with the unit for doctors, family members and patients. Tr. at 75. The RD characterized this as "to basically be the go-to person for questions or issues that arise." D&D at 14. If doctors have a need or concern, they contact the Charge Nurse. If family members need information about a patient, they contact the Charge Nurse. If patients need information, for example, why they have been waiting so long to be seen in the emergency room, they contact the Charge Nurse. Fourth, the Charge Nurse makes rounds with representatives of other departments to discuss patient needs, such as plans for

discharge. Tr. at 93. Fifth, the Charge Nurses perform data collection and reporting functions. In some units, they insure that the narcotics control sheet has been properly completed during the shift. Tr. at 91. This requires "reviewing that sheet, making sure that everything is complete on it that everyone has filled in all those blanks that they are supposed to have." Tr. at 91. On other units they maintain a "Charge Nurse sheet that identifies many different things that occurred during the shift," including how many patients were admitted during that shift, how many transfers in, how many transfers out, how many patients were receiving blood." Tr. at 95. Charge Nurses also may perform "chart audits," for example, to determine if certain procedures have been performed in a timely manner. Tr. at 96, 576. Sixth, Charge Nurses reorder supplies. E. Ex. 14. Seventh, they inform the Nurse Manager of acute changes in the status of any patient and of any other problems on the unit. E. Ex. 14. Finally, some other obviously nonsupervisory tasks are performed by Charge Nurses only in particular units. In Intermediate Care, they "watch the cardiac monitors while the nurses are out in the hallways." Tr. at 244. In Mental Health, the Charge Nurses handle discharges, "they do all the discharge instructions and make sure the patient has their belongings and is out the door and has transportation, et cetera." Tr. at 308. In the Med Surg Units, "they are expected to check the orders and note orders and transcribe medications onto the medication administrative record. They interact with doctors. They actually place calls for doctors so that the other nurses are freed up to do patient care. They also collect a lot of data." Tr. at 376. In the Immediate Care (IMC) Unit, the Charge Nurse has to "run a strip" from the cardiac monitors on every patient each shift, she "tries to run the lab reports for all the patients," she checks the "crash carts" used if a patient needs to be resuscitated, and assigns new patients to beds. Tr. at 571-75. Thus, the Charge Nurses provide nursing care and have many administrative and other functions that are clearly nonsupervisory.

In contrast, the only allegedly supervisory function that received extended treatment at the hearing was the assignment of patients to nurses. As explained further in subsection (3)(a) below, the RD correctly found that "[i]t usually takes only a few minutes to do the assignments."

D&D at 14.

a. The Employer Failed to Prove Assignment

The brief of Amicus AFL-CIO sets forth the appropriate construction of the term "assign." The Employer failed to present any evidence of the requisite type of long-term assignment of employees.

The Charge Nurses do not assign nurses or other staff to classifications, shifts, or units. This task is performed by the Clinical Managers. D&D at 7, 8. Requests for shift changes must be made to the Clinical Managers. D&D at 8. Any trades of shifts must be approved by the Clinical Managers. D&D at 8. "The charge nurse does not assign employees to shifts." D&D at 13.

If staffing is not adequate on a particular shift or particular unit due, for example, to employees not reporting to work, the Clinical Supervisor is responsible for taking action, authorizing overtime, using in-house flex pool nurses, or calling on outside agency nurses. D&D at 8. The Clinical Supervisor is responsible for "staffing for the next shift," including "if someone is calling off sick" and "calling staff if we have to line up staff." Tr. at 41. It is the Clinical Supervisor that has authority to move staff from one unit to another. Tr. at 99-100. It is the Clinical Manager or Clinical Supervisor that can require an employee to stay on duty beyond their regular shift. Tr. at 532-33. Charges Nurses cannot authorize overtime. Tr. at 542. If an assigned nurse does not appear on the unit, the Charge Nurse calls the staffing office. D&D at 13.

Thus, the Charge Nurses do not assign employees to classifications, shifts, or units. They do not assign employees as that term is used in §2 (11).

b. The Employer Failed to Prove Responsible Direction

The brief of the Amicus AFL-CIO sets forth the appropriate construction of the term "responsibly to direct." The Employer failed to present any evidence of the requisite type of responsible direction of employees. First, the Charge Nurses do not direct employees in an entire

department. The Hospital employs such supervisors, akin to the foreman Congress sought to exclude through the Taft-Hartley Amendments, but they are the heads of the various departments, dietary, laundry, and most relevant, nursing in the person of the Nursing Site Leader.

Second, the Charge Nurses do not "direct[ ]other employees" on an on-going basis, but merely occasionally "directs the manner of others' performance of discrete tasks." In fact, the record is virtually devoid of evidence of any form of direction. But the evidence that exists is all of sporadic direction to perform discrete tasks – to perform an EKG, to collect a urine specimen, to insert a Foley. Tr. at 503-04, 564, 598. *See infra* § IV, A.

Third, all the Charge Nurses work at their trade, as nurses, and give directions that are incidental to the performance of their own duties. All the Charge Nurses have a patient load. They are responsible for the care of patients. Incidental to carrying out their own responsibilities, they request that CNAs perform tasks that fall within the assistants' duties.

Finally, there are a number of admitted supervisors – the Nursing Site Leader, the Clinical Supervisors, the Clinical Managers and the Assistant Clinical Managers who exercise supervisory authority over the nurses and the CNAs.

The Employer failed to carry its burden of proving that the Charge Nurses responsibly direct other employees.

3. The Employer Failed to Prove the Exercise of Independent Judgement

a. In the Assignment of Patients

The RD found that "[t]he assignment of staff to patients is much more perfunctory in practice than the Employer's written assignment policy indicates." D&D at 14. "It usually takes only a few minutes to do the assignments." D&D at 14. The one nurse who gave a time estimate for completing the assignment function estimated "[a] couple minutes." Tr. at 514. In evaluating the nature of the judgment that is used to perform this task, the Board should examine the sample assignment sheet that is in the record at Pet. Ex. 5. It shows that the Charge Nurse in the Immediate Care (IMC) Unit on December 30, 2001, on the 7-3 shift, assigned patients to six

nurses, either three or four to each of the non-charge nurses on duty. Clearly, the form was filled out in a couple of minutes or less.

Again and again, the witnesses explained that the assignment function was simply a matter of evenly dividing the work. The Assistant Clinical Manager from the Mental Health Unit testified that the "primary function of the charge nurse" is to "distribute the workload evenly." Tr. at 302. She reiterated that the goal was to "make sure each person has the same amount of work." Tr. at 333. This is true both in initial assignments at the start of a shift and in the assignment of a new admission when "she's going to give it to someone who has a lesser workload . . . in order to evenly distribute it." Tr. at 334. The question is simply "whether you are up next on the rotation to get a new patient." Tr. at 453. Similarly, in the Immediate Care (IMC) Unit, "we go by who did an admission the day before" or "who has three patients instead of four." Tr. at 575. The Board has consistently held that dividing work to maintain an even workload dos not require independent judgment. *See, e.g., KGW-TV*, 329 NLRB 378, 382 (1999); *Byers Engineering Corp.*, 324 NLRB 740, 741 (1997); *Parkview Manor*, 321 NLRB 477, 478 (1996); *Providence Hospital*, 320 NLRB 717, 727(1996), *enf'd*, 121 F.3d 235 (9th Cir. 1997); *Ohio Masonic Home*, 295 NLRB 390, 395 (1989).

The even division of the workload is also a collective process. In the Immediate Care (IMC) Unit, one nurse explained how, after all the nurses listen to report by the outgoing shift, the Charge Nurse asks the others "who knows which patients have the highest acuity. We call them completes." Tr. at 565. "So then we figure out who the completes are, amongst – as a group." Tr. at 565. The Charge Nurse then simply "divide[s] up the completes and make[s] sure they are divided up evenly." Tr. at 566. In other units, staff, even the aides, arrange their own assignments. Tr. at 568.

In some units, the assignment is even more standardized. For example, in the emergency room there is simply a rotation through different areas. Tr. at 510-11.

The testimony reveals that the only other factor consistently considered in the assignment

of patients to nurses other than even distribution is continuity. If a patient has been assigned to a nurse on prior days, the assignment is continued. Tr. at 335. The Assistant Clinical Manager for In-patient Rehabilitation testified that the Charge Nurses "try to keep our full-time nurses in the same area that they normally would work." Tr. at 434-35. It is "most likely" that if a nurse "is working four days in a row, then she would go back to that same block . . . of rooms each day." Tr. at 445. Similarly, in the Immediate Care (IMC) unit, a Rotating Charge Nurse testified, "We look at who was here the day before. . . . And try and give them the same assignment that they had, if they want it back." Tr. at 567. Like balancing the workload, assignment of patients to the nurses who cared for them the day before does not require independent judgment.

The only specific examples of variances from these standard procedures for assigning patients also did not require independent judgment. For example, the Nursing Site Leader testified that in Intermediate Care, "if you have a patient who is on nitrol drip, for instance, you're not going to assign that patient to a med-surg nurse who was pulled into the unit to work for that day." Tr. at 269. A nurse from the Immediate Care (IMC) Unit similarly explained that when she worked with a nurse from the second floor who was an LPN "she could not be assigned any cardizone drips or nitroglycerin drips or any cardiac patient." Tr. at 566. Thus, an obvious and known lack of capacity to perform a specific task is considered in not assigning a nurse to a patient whose doctor has ordered the task to be performed. This does not require independent judgment under long-standing Board precedent. *See, e.g., Hausner Hard-Chrome of Ky.*, 326 NLRB 426, 427 (1998); *S.D.I. Operating Partners*, 321 NLRB 111, 111 (1996); *Providence*, 320 NLRB at 731; *Clark Machine Corp.*, 308 NLRB 555, 555-56 (1992); *Injected Rubber Products Corp.*, 258 NLRB 687, 689 (1981); *Weyerhauser Timber Co.*, 85 NLRB 1170, 1173 (1949).[70]

While the Employers' witnesses presented conclusionary testimony about pairing patients

---

[70]The Employer witnesses also speculated that Charge Nurses might consider language ability, ethnicity and gender when assigning patients to nurses. Tr. at 307, 302. But these are also obvious and known qualifications and thus, for example, it does not require independent judgment to match a Spanish-speaking patients with a Spanish-speaking nurse.

to nurses based on the unique needs of the latter and capacities of the former, no specific examples were given of such individualized consideration requiring the exercise of independent judgment. As in *Providence*, "The general testimony that leaders match patient needs to RN skill is unpersuasive." 320 NLRB at 733. The specific testimony of the Charge Nurses, with long experience in a variety of units, about how the task was actually performed was to the contrary. In fact, one Rotating Charge Nurse from the Immediate Care (IMC) Unit testified that all the regular staff has "the same level of skill with respect to everything they are required to do on the unit." Tr. at 593.

The Employer failed to carry its burden of proving that the Charge Nurses exercise independent judgment in assigning patients to nurses.

b. In the Assignment of Breaks

The Employer also did not carry its burden of proving that Charge Nurses exercise independent judgment in the assignment of breaks. In most units, there are only two break times so "the people who go on the first break are relieved by the people who go on the second break." Tr. at 250. The evidence indicates "most of the staff have kind of a regular time when they go." Tr. at 314. Thus, virtually no judgment is needed.

The RD found that the Charge Nurses "main goal in assigning breaks is to make sure the unit is covered at all times." D&D at 14. Essentially, the Nursing Site Leader explained, "they're looking at the number of staff that are there, the number of RN staff. They're dividing them, looking at the number of nurse aides, diving them up, and they cover each other." Tr. at 250. She continued, "you're dividing the number to make sure you have a group of people left on the floor in equal number. So you're sending half of your staff on each of the breaks." Tr. at 252. Again, the Board should examine the sample assignment sheet in the record. It reveals nurses being evenly divided between breaks 1 and 2. Pet. Ex. 5. This does not require independent judgment.

Indeed, in some units, the Charge Nurse does not even make the routine decision about

which half of the staff to send on which break. One Charge Nurse testified that the employees "just tell you when they want to go and they know that only – they split it into three lunches and they say one, two, or three, and they work it out." Tr. at 383. "[I]t is just an effort between the staff themselves." Tr. at 533. In the Immediate Care (IMC) Unit, a Rotating Charge Nurse explained, "We just ask who wants to go first, who wants to go second." Tr. at 568.

The Employer failed to carry its burden of proving the exercise of independent judgment in the assignment of breaks.

c. In the Assignment of Discrete Tasks or Direction

As explained above, there was next to no evidence presented about the assignment of discrete tasks or direction. The evidence in the record makes clear that the Charge Nurses' limited assignment of discrete tasks is constrained by doctors' orders, care plans, and Hospital policies and procedures to such an extent that it does not require independent judgment.

In general, all patients are treated pursuant to a detailed set of doctors' orders. The orders cover "[t]esting, diets, activity, medications, IV therapies . . . . monitor[ing] the input and output of the patient . . . . vital signs, routine, or vital signs that are specific." Tr. at 207. Each patients also has an individualized, written care plan. In conjunction with doctors' orders and care plans, care is provided pursuant to a set of "Guidelines of Patient Care." Pet. Ex. 4. They provide that patient care "is provided in compliance with established guidelines." Pet. Ex. 4. Among the guidelines are "Policies and Procedures" which are "step by step instructions on how to perform a psychomotor skill such as insert or remove, attach or disconnect, etc." Pet. Ex. 4. The Guidelines also include "Protocols" which are "formats for defining management of broad patient problems or issues. . . . Examples of protocols are the restraint protocol, fall protocol, ambulation protocol." Pet. Ex. 4. These Hospital Guidelines are "detailed enough to prescribe how to perform certain tasks." Tr. at 208. The Guidelines identify who can perform the task, "the equipment that would be used," and "the steps to follow." Tr.at 209-10. The Guidelines are kept in every unit. Tr. at 209.

Thus, all nurses, not just the Charge Nurses, assign discrete tasks required by doctors' orders and care plans to the appropriate, assigned staff member (e.g., a CNA or an Operating Room Technician). Both the nurse and the other staff member ordinarily know how to perform the task, but can consult the Guidelines if they do not. All the specific examples of assignment or direction of tasks discussed in the record fit this pattern.

For example, an Emergency Room nurse testified that she might direct a technician to perform an EKG, but she knows that an EKG must be done because "[i]t would be an order by the doctor and it would be indicated on the chart that it needed to be done." Tr. at 503-04. Similarly, an Immediate Care (IMC) Unit nurse was asked, "What type of task would you ask an aide to complete?" She answered, "For instance, collect a urine specimen that the doctor ordered." Tr. at 564. Later she explained that the staff knew what "procedures needs to be done" from "[t]he doctor's order" and they knew how to perform the procedure from "policies . . . like insert a Foley, you know, there is a procedure for that." Tr. at 598. Summarizing these constraints, the Hospital's Guidelines for Care Intent Statement provides, "Care is provided based upon clinical policy and procedure, protocols, clinical pathways, care plans etc." Pet. Ex. 4 at 4.[71]

The evidence therefore shows that, in the assignment of discrete tasks or in directing the performance of discrete tasks, the Charge Nurse simply asks the assistants to perform tasks required by doctors' orders or care plans that fall into the assistants' areas of responsibility. The assistants know how to perform the tasks or the nurse or assistant can consult Hospital policies for direction. The Employer failed to carry its burden of proving the exercise of independent judgment in this form of assignment or direction.

---

[71]The Mental Health Unit appears to operate somewhat differently as there was testimony that the Charge Nurse assigned staff to make rounds, to sign in visitors, and to serve meals. But again, the only criteria identified for making these assignments was to "even out the workload." Tr. at 312.

4. The Secondary Indicia Support the Conclusion that the Charge Nurses Are Not Supervisors

Each unit has a Clinical Manager and one or two Assistant Clinical Managers. Tr. 28, 32; Er. Ex. 1, 12. An admitted supervisor is always on site at the Hospital. This is either the Nursing Site Leader, Clinical Supervisors, Clinical Managers, or Assistant Clinical Managers.[72] D&D at 6-7. In addition, the Nursing Site Leader and the Clinical Managers are on-call 24 hours a day. Tr. at 185, 189; D&D at 7.[73] The Hospital's Job Responsibilities Summary provides that the Clinical Manager has "twenty-four hour responsibility for . . . [m]anag[ing] resources ([including] personnel . . .)." Pet. Ex. 3.[74] . Hospital policies require that a "charge nurse encountering any sort of patient, operational, or ethical problem is expected to notify a clinical manager or clinical nurse supervisor." D&D at 7. Nurses do, in fact, call the Clinical Manages at home. Tr. at 187.

If the Charge Nurses are classified as supervisors, there would be an unreasonable ratio of supervisors to supervised on many shifts in many units. For example, in the Mental Health Unit on the day shift, there would be eight to 10 supervisors (Clinical Manager, Assistant Clinical Managers and RNs) and nine to 10 supervised (LPNs, Mental Health Workers and Desk Secretary). Tr. at 291. In the Intermediate Care Unit, the ratio on the day shift would be five supervisors (Clinical Manager and four RNs) to four supervised (LPN, two aides and one secretary). Tr. at 560.

B. Beverly Failed to Prove the Nurses are Supervisors

As at Oakwood, Beverly seeks to exclude RNs and LPNs employed at its nursing home on the grounds that they have supervisory authority while acting as Charge Nurses. The

---

[72]The only units that do not have at least one Assistant Clinical Manager are PACU-Outpatient Surgery, Operating Room, and Pain Clinic. Tr. at 46.

[73]As is the Chief Administrative Officer. Tr. at 185.

[74]The Hospital's "Organizational Plan/Nursing" does not even list Charge Nurses. Pet. Ex. 2.

Employer contends that the Charge Nurses both assign and responsibly direct employees.[75] As at Oakwood, the Employer failed to carry its burden of proof. The Charge Nurses play only a coordinating role. As the RD points out, one nurse described her function as Charge Nurse as "a coordinator." D&D at 9. But they are not supervisors.

1. Occasional Assumption of Charge Nurse Role is Not Sufficient to Deprive Nurses of the Act's Protection

The evidence is unclear under what circumstances and how often the various nurses serve as Charge Nurses. Thus, whether the Employer must prove that nurses hold supervisory authority during a majority of their working hours or only during a "regular and substantial" number of hours, the Employer failed to carry its burden of proof.

Among the 12 LPNs, for example, the Employer contends that all but one serve as Charge Nurse, tr. at 477, but LPNs only serve as Charge Nurse on the first floor (never on the second floor) and also serve as Med Pass Nurse and perform "primary resident care." Tr. at 19. One LPN testified she only served as Charge Nurse when "someone is sick." Tr. at 518. In fact, the Employer did not even argue that the nurses all satisfied the regular and substantial test. The Employer contended at the hearing only that 10 of the 11 LPNs "work . . . either regularly or at times as a charge nurse." Tr. at 482. The Employer simply failed to carry its burden on this issue.

2. The Employer Failed to Prove Assignment or Direction

As at Oakwood, the Charge Nurses perform many functions that are not even arguably supervisory. "Most of [their day] is doing hands on care." Tr. at 325. One Charge Nurse testified, "I'm working hand in hand next to my nursing assistant changing diapers, repositing people, and then when I am done helping her do what she needs to do and she can go on and do

---

[75]The Employer also argued that the Charge Nurses evaluate, discipline, adjust grievances, and effectively recommend the recall of employees. Because either these functions are not indicative of supervisory status under Board law or because the evidence was clearly insufficient to prove that the Charge Nurses perform any of these supervisory functions as they have been consistently defined in the Board jurisprudence, these arguments are not addressed here.

the stuff that she does by herself, I am then responsible for the medical needs of the people that I take care of." Tr. at 327. In addition to direct patient care, Charge Nurses spend several hours "charting." Tr. at 177, 178, 233-34. Even the Director of Nursing (DON) admitted, "They don't just supervise CNA's . . . . They do resident assessments part of their time. They do charting, they call physicians, they talk to relatives, they deal with patients, they give hands-on care." Tr. at 483.

a. The Employer Failed to Prove Assignment

The Employer failed to present any evidence of the requisite type of on-going assignment of employees to classifications, shifts, or units. The Assistant Director of Nursing (ADON) "determines the work schedules for nurses and CNAs, including planned days off and vacations." D&D at 3; Tr. at 197. CNAs are preassigned not only to shift and floor, but even to specific patient rooms. The collective bargaining agreement provides for CNAs to bid on shift, floor and block of resident rooms or section. The DON testified, "It all goes with the job postings. One particular CNA will work day shift, eight hours, and she has section 1, and it's room 101 through 105." Tr. At 26. Only in "unusual situations" do CNAs work with residents outside the sections they are preassigned. D&D at 5. "[M]ostly," the DON testified, "the CNAs will stay with their sections." Tr. at 68. "[E]ach group of people takes care of the same – pretty much the same residents every day." Tr. at 177.

b. The Employer Failed to Prove Responsible Direction

The Employer failed to present any evidence of the requisite type of responsible direction of employees. First, the Charge Nurses do not direct employees in an entire department. Here, such supervisors, akin to the foreman Congress sought to exclude through the Taft-Hartley Amendments, are the Director of Nursing and the ADON.

Second, the Charge Nurse does not "direct[ ]other employees" on an on-going basis, but merely occasionally "directs the manner of others' performance of discrete tasks." Again, the record is virtually devoid of evidence of any form of direction. But the evidence that exists is all

of sporadic direction to perform discrete tasks: to monitor a resident when he or she is eating, to bath a resident, to clip a resident's nails, to keep a room orderly, to change a wet resident, to empty a catheter. Tr. at 409, 410, 503..

Third, all the Charge Nurses work at their trade, as nurses, and give directions that are incidental to the performance of their own duties. All the Charge Nurses perform hand-on patient care, chart and perform other nursing duties. They are responsible for the care of patients. Incidental to carrying out their own responsibilities they request that CNAs perform tasks that fall within the assistants' duties.

Finally, there are a number of admitted supervisors – the DON, ADON, and three Resident Care Managers who exercise supervisory authority over the nurses and the CNAs.

The Employer failed to carry its burden of proving that the Charge Nurses responsibly direct other employees.

3. The Employer Failed to Prove Independent Judgment

a. In Assignment

Only in unusual and rare circumstances do Charge Nurses have even limited authority to assign. They occasionally play a role in reassigning residents to CNAs and in extending or shortening CNAs' shifts. The limited form of reassignment performed by Charge Nurses does not require independent judgment. It is done only in unusual circumstances and for clearly evident reasons, for example, "if one floor is down [on staff]," because a CNA called in sick, a replacement would be located. Tr. at 67. Conversely, "If [the Administrative Assistant] made a mistake and overstaffed," a CNA would be sent home. Tr. at 168.

It does not require independent judgment to determine when this limited form of reassignment is needed. The only occasions when additional personnel is required that are discussed in the record are when an employee fails to report and the only occasions when all existing personnel are not required that are discussed in the record is when there is an error in scheduling. Recognizing these situations does not require independent judgment.

Nor do the Charge Nurses exercise independent judgment in deciding who to reassign. The RD correctly found that the collective bargaining agreement "contains detailed provisions for filling open shifts on the work schedule." D&D at 4. *See* Er. Ex. 31 at 13-14, Art. XVI (CBA). Essentially, it requires that work be offered to employees in order of seniority and, if no one voluntarily takes the work, employees be mandated to work in the reverse order. D&D at 4. However, in those instances where an opening occurs after the schedule is posted (i.e. those in which the Charge Nurses might be involved), even employees who are "mandated" to appear have a contractual right to refuse without sanction. Er. Ex. 31 at 14, § 16.01-B. The DON clearly explained, "You call people in for an extra shift for overtime [on a voluntary basis] starting with the highest seniority, been there the longest, and you mandate [on an involuntary basis] starting with the lowest seniority." Tr. at 70. That this task does not require independent judgment is demonstrated by the fact that during the day it is done by a clerical employee, Deb Bowman, the nursing Administrative Assistant. Tr. at 167. During the evening or at night, when an employee calls in sick, the first floor Charge Nurse, who is usually an LPN, performs this essentially clerical function of calling "for volunteers from a list" because she has more time than the second floor Charge Nurse who is an RN. D&D at 7 *See also* tr. at 318, 328, 490. This is done according to a "contractual formula." Tr. at 167. When there is overstaffing, the same formula governs: "if no one volunteers lowest seniority." Tr. at 168.

If there is a staffing problem that cannot be addressed pursuant to the contractual formula, the Charge Nurses call the ADON. One Charge Nurse testified, "If we – for example, if we have had more call-ins than I am able to fill from the seniority list, and I need some advice or permission to overstep what the standard guidelines are for calling somebody in I typically call Jacie [the ADON]. . . When Jacie is on vacation I call Sue [the DON]." Tr. at 313. *See also* tr. at 490, 520-21.

Another Charge Nurse testified that she did not have authority to pull staff from the other floor. Tr. at 232. Yet another explained that when it was necessary to do this, she obtained

instructions from the ADON and would instruct the CNA "'Jacie told you you had to go up.'" Tr. at 521-22.

If additional staff cannot be located, the Charge Nurse may reassign patients to assistants. But the objective is simply to "equalize the work." Tr. at 68. The "right" that the Charge Nurse has is "the right to equalize work." Tr. at 411. This is usually done by simply expanding the assigned sections or blocks of rooms to encompass the section of the missing CNA.[76] The DON explained, "the way it's generally done all the sections just get a little bit bigger and then they encompass the one who went home." Tr. at 209. In fact, the CNAs ordinarily reassign the patients themselves. When a floor is short staff, for example, if a CNA is ill, residents are reassigned "among the CNAs with little or no input from nurses." D&D at 7. A first floor Charge Nurse explained, "they usually work it out amongst themselves, like if there's a call-in or something." Tr. at 493. Another Charge Nurse testified about a shift when a large number of employees were out with the flu and the CNAs "got their heads together and decided who was working where, divided the two floors up. . . . I saw them at the second floor desk saying, okay I will take this group of rooms, you take that group of rooms. The decision – the nursing assistants did all of the planning themselves. The nurses weren't even involved in it." Tr. at 316. Thus, this sporadic and limited form of reassignment or expansion of duties is often done by the CNAs themselves and does not require independent judgment.

The Charge Nurses who testified stated that they did not have authority to approve an employee leaving work early, but referred them to the ADON. One Charge Nurse testified, "I ask them to go see Jacie Marchetti if they want time off." Tr. at 225, 231-32.. Asked if "they tell you they're going home rather than you telling them to go home," another Charge Nurse answered, "Correct." Tr. at 314.

---

[76]Of if an employee is working as "a float," the Charge Nurse simply assigns the absent employee's residents to the float. Tr. at 210.

b. In Assignment of Discrete Tasks or Direction

As stated above, there is virtually no evidence in the record of Charge Nurses' specific assignment of discrete tasks or directions to perform discrete tasks. The Employer's witnesses' testimony largely consisted of vague, general statements concerning monitoring and correcting. The DON, asked, "what does that involve though," answered:

> Oh, they will make sure that there is monitoring – a specific instances that there is monitoring going on – during any meal time a resident can't be left alone during a meal time. They make sure that the residents baths are done properly and toe nails clipped and fingernails clipped and the ward order in the room is good. [Tr. at 409.]

Asked for a specific example of how a Charge Nurse might "direct the work of a CNA," the DON answered, "If a resident – real specific is if a resident is wet and the CNA isn't going to change the resident, the LPN would say the resident needs changing now." Tr. at 410. Asked if she could ask a CNA to perform a specific task, one Charge Nurse answered, "You mean like empty a catheter. . . . Oh, yeah, I can tell them to go empty a catheter or that's their job." Tr. at 503. None of these examples involve the exercise of independent judgment. It is obvious that a resident is wet, a catheter is full, a resident is not being monitored while eating, and that a resident has not been bathed or had his or her nails clipped. In each case, an assistant is already assigned to the resident and the task that obviously needs to be performed is within the assistant's duties. It requires no independent judgment to tell the assistant to perform the task.

The few actual (in contrast to hypothetical) examples of direction that are discussed in the record also do not suggest that independent judgment is required. For example, one Charge Nurse instructed a CNA that she was only to receive emergency phone calls at night, but this was because "[t]here had been a memo put out not too long before that . . . staff was not to get personal phone calls at work. I was just following through." Tr. at 347. In general, the Charge Nurse explained that she counseled employees "as a reminder of the policy of Beverly Enterprises." Tr. at 349.

In general, while caring for the elderly residents of a nursing home is work of the utmost

importance, the tasks it requires each day are almost always the same. As the D.C. Circuit observed, "the vast majority of the tasks performed by both the LPNs and Certified Nursing Assistants (CNAs) . . . are the same from day to day." *Beverly Enters.-Pa. v. NLRB*, 129 F.3d 1269, 1270 (D.C.Cir. 1997). In this case, the DON testified, "each group of people takes care of the same – pretty much the same residents every day" and, as a result, "[t]he employees are to – they have their job, they know what the job is." Tr. at 177. Simply reminding a CNA to perform as task which he or she performs every day does not require independent judgment.

The Employer failed to carry its burden of proving the exercise of independent judgment.

4. The Secondary Indicia Support the Conclusion that the Charge Nurses Are Not Supervisors

In addition to the DON and the ADON, there are three Resident Care Managers with "overall responsibility for a team of nurses and CNAs on a designated unit." D&D at 4. Their responsibilities include "supervising nursing duties." D&D at 4. Their position description indicates that this responsibility continues for "24 hours." D&D at 4. There are eight RNs, 12 LPNs and 36 CNAs at the facility. D&D at 4. Thus, the ratio of admitted supervisors to employees in the nursing department is a reasonable 5 to 56 or approximately 1 to 10. If the Charge Nurses are misclassified as supervisors, the ratio becomes 23 to 37 or less than 1 to 2. *See* D&D at 11, 17.

While the Employer points out that during part of the evening and the entire night shift and on some weekends, the Charge Nurse is the highest ranking employee physically present in the facility, this does not suggest the Charge Nurse is a supervisor. Board law is plain on that point. Morever, there are fewer employees on duty and less activity at night. D&D at 11. On the night shift on the first floor, for example, the only nursing employees on duty are the Charge Nurse and one CNA. Tr. at 24. Finally, the admitted supervisors are available and play an active role even when they are not on site. The DON testified, "I made myself available. The numbers are there, my cel phone number." Tr. at 183. The nurses testified repeatedly that, "[i]f there's a problem at the facility and nobody's there . . . . [t]ypically I would call – if it's something nursing

I would call Jacie [the ADON]." Tr. at 312. As the RD found, "the evidence shows that the charge nurses do in fact routinely call the DON or ADON, or even the facility administrator, regarding issues such as staff shortages that the collectively-bargained 'mandate' procedure does not satisfy." Sup.D&D at 6.

CONCLUSION

For the above-stated reasons, the Board should hold that the nurses in both these cases are employees and not exempt supervisors.

Respectfully submitted,

Daniel W. Sherrick, General Counsel
Blair Simmons, Esq.
UAW, International Union
8000 East Jefferson Avenue
Detroit, MI 48214-2699
(313) 926-5216

Paul Whitehead, General Counsel
Daniel M. Kovalik, Esq.
United Steelworkers of America
Five Gateway Center, Suite 807
Pittsburgh, PA 15222
(412) 562-2549

John C. Dempsey, General Counsel
Larry P. Weinberg, General Counsel
AFSCME, Office of General Counsel
1101 17th Street, N.W., Suite 900
Washington, D.C. 20036
(202) 775-5900

David J. Strom, General Counsel
American Federation of Teachers
555 New Jersey Avenue, N.W.
Suite 200
Washington, D.C. 20001
(202) 393-7472

Patrick M.. Scanlon, General Counsel
Communications Workers of America
502 Third Street, N.W., Suite 800
Washington, D.C. 20001
(202 434-1234

Patrick J. Szymanski, General Counsel
International Brotherhood of Teamsters
25 Louisiana Avenue, N.W.
Washington, D.C. 20001
(202 624-6945

Richard Griffin, General Counsel
International Union of Operating Engineers
1125 17th Street, N.W.
Washington, D.C. 20036
(202) 429-9100

Michael S. Bearse, General Counsel
Laborers' International Union of North America
906 16th Street, N.W.
Washington, D.C. 20006
(202) 737-8320

Melvin S. Schwarzwald, General Counsel
Office and Professional Employees International Union
Schwarzwald & McNair
1300 East Ninth Street, Suite 616
Cleveland, OH 44114
(216) 566-1600

Judith A. Scott, General Counsel
Service Employees International Union
1313 L Street, N.W.
Washington, D.C. 20005
(202) 898-3453

Robert E. Funk, Jr., General Counsel
United Food and Commercial Workers
1775 K Street, N.W.
Washington, D.C. 20005
(202) 223-3111

By: Daniel W. Sherrick
Daniel W. Sherrick - GRS

Paul Whitehead
Paul Whitehead - GRS

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing Brief of the Petitioners UAW and Steelworkers and Amicus AFL-CIO Unions representing nurses was served by overnight express on the following this 22nd day of September 2003.

Michael T. Manley
Blake & Uhlig
753 State Ave., Suite 475
Kansas City, KS 66101

William M. Thacker
Claire S. Harrison
Dykema Gossett PLLC
315 E. Eisenhower Parkway, Suite 100
Ann Arbor, MI 48108

Penelope J. Phillips
Frederick W. Vogt
Felhaber, Larson, Fenlon & Vogt, P.A.
601 Second Ave. South, Suite 4200
Minneapolis, MN 55402-4302

Norman Mott
Shields, Mott, Lund, LLP
650 Poydras St.
New Orleans, LA 70130

Regional Directors Regions 7, 15, and 18.

Daniel W. Sherrick gms

Daniel W. Sherrick